

		FOR OFF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0040394</u></p> <p>Facility Name: <u>GLENWOOD CARE CENTER</u></p> <p>Address: <u>222 N. HAMMES</u> <u>JOLIET</u> <u>60435</u> Number City Zip Code</p> <p>County: <u>WILL</u></p> <p>Telephone Number: <u>(847) 647-1717</u> Fax # <u>(847) 647-0222</u></p> <p>IDPA ID Number: <u>36-3873066</u></p> <p>Date of Initial License for Current Owners: <u>04/01/93</u></p> <p>Type of Ownership:</p> <table><tr><td><input type="checkbox"/></td><td>VOLUNTARY,NON-PROFIT</td><td><input checked="" type="checkbox"/></td><td>PROPRIETARY</td><td><input type="checkbox"/></td><td>GOVERNMENTAL</td></tr><tr><td><input type="checkbox"/></td><td>Charitable Corp.</td><td><input type="checkbox"/></td><td>Individual</td><td><input type="checkbox"/></td><td>State</td></tr><tr><td><input type="checkbox"/></td><td>Trust</td><td><input type="checkbox"/></td><td>Partnership</td><td><input type="checkbox"/></td><td>County</td></tr><tr><td>IRS Exemption Code</td><td></td><td><input type="checkbox"/></td><td>Corporation</td><td><input type="checkbox"/></td><td>Other</td></tr><tr><td></td><td></td><td><input checked="" type="checkbox"/></td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>Other</td><td></td><td></td></tr></table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u></p>	<input type="checkbox"/>	VOLUNTARY,NON-PROFIT	<input checked="" type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL	<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State	<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County	IRS Exemption Code		<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other			<input checked="" type="checkbox"/>	"Sub-S" Corp.					<input type="checkbox"/>	Limited Liability Co.					<input type="checkbox"/>	Trust					<input type="checkbox"/>	Other			<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2003</u> to <u>12/31/2003</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table><tr><td rowspan="3">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>SHERWIN I. RAY</u></td></tr><tr><td>(Title) <u>PRESIDENT</u></td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td></tr><tr><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u></td></tr><tr><td>(Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u></td></tr><tr><td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td></tr><tr><td colspan="2"><p>MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p></td></tr></table>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>SHERWIN I. RAY</u>	(Title) <u>PRESIDENT</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u>	(Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u>	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>	<p>MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	
<input type="checkbox"/>	VOLUNTARY,NON-PROFIT	<input checked="" type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL																																																								
<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State																																																								
<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County																																																								
IRS Exemption Code		<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other																																																								
		<input checked="" type="checkbox"/>	"Sub-S" Corp.																																																										
		<input type="checkbox"/>	Limited Liability Co.																																																										
		<input type="checkbox"/>	Trust																																																										
		<input type="checkbox"/>	Other																																																										
Officer or Administrator of Provider	(Signed) _____																																																												
	(Type or Print Name) <u>SHERWIN I. RAY</u>																																																												
	(Title) <u>PRESIDENT</u>																																																												
Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>																																																												
	(Date) _____																																																												
	(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u>																																																												
	(Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u>																																																												
	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>																																																												
<p>MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>																																																													

Facility Name & ID Number GLENWOOD CARE CENTER

0040394 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	203	Skilled (SNF)	203	74,095	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	203	TOTALS	203	74,095	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			3,873	3,873	8
9	SNF/PED					9
10	ICF	37,620	3,646	791	42,057	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,620	3,646	4,664	45,930	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.99%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 04/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 04/01/93 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 29 and days of care provided 3,873

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **GLENWOOD CARE CENTER** # **0040394** Report Period Beginning: **01/01/2003** Ending: **12/31/2003**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	192,079	30,308	12,416	234,803		234,803	2,562	237,365			1
2	Food Purchase		220,796		220,796	(23,324)	197,472	(1,093)	196,379			2
3	Housekeeping	187,209	33,978		221,187		221,187		221,187			3
4	Laundry	58,143	15,300		73,443		73,443		73,443			4
5	Heat and Other Utilities			160,670	160,670		160,670	175	160,845			5
6	Maintenance	57,164	22,493	33,519	113,176		113,176	9,334	122,510			6
7	Other (specify):* Security	30,167		11,765	41,932		41,932		41,932			7
8	TOTAL General Services	524,762	322,875	218,370	1,066,007	(23,324)	1,042,683	10,978	1,053,661			8
	B. Health Care and Programs											
9	Medical Director			8,400	8,400		8,400		8,400			9
10	Nursing and Medical Records	1,732,306	109,615	3,606	1,845,527		1,845,527	24,849	1,870,376			10
10a	Therapy	60,158	6,121	54,749	121,028		121,028	(2,856)	118,172			10a
11	Activities	91,380	4,081		95,461		95,461		95,461			11
12	Social Services	130,368		2,320	132,688		132,688		132,688			12
13	Nurse Aide Training											13
14	Program Transportation			109	109		109		109			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,014,212	119,817	69,184	2,203,213		2,203,213	21,993	2,225,206			16
	C. General Administration											
17	Administrative	95,031			95,031		95,031	54,155	149,186			17
18	Directors Fees											18
19	Professional Services			272,060	272,060		272,060	(10,981)	261,079			19
20	Dues, Fees, Subscriptions & Promotions			29,056	29,056		29,056	389	29,445			20
21	Clerical & General Office Expenses	93,930	13,827	176,158	283,915		283,915	(82,747)	201,168			21
22	Employee Benefits & Payroll Taxes			416,201	416,201	23,324	439,525		439,525			22
23	Inservice Training & Education			2,152	2,152		2,152	731	2,883			23
24	Travel and Seminar			2,353	2,353		2,353	656	3,009			24
25	Other Admin. Staff Transportation			2,768	2,768		2,768	2,436	5,204			25
26	Insurance-Prop.Liab.Malpractice			147,125	147,125		147,125	2,541	149,666			26
27	Other (specify):*							36,067	36,067			27
28	TOTAL General Administration	188,961	13,827	1,047,873	1,250,661	23,324	1,273,985	3,247	1,277,232			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,727,935	456,519	1,335,427	4,519,881		4,519,881	36,218	4,556,099			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT	XVIII B 35-2	7,200
	REPAIRS & MAINTENANCE		5,216
			0
			12,416
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		0
			0
			0
5	HEAT & OTHER UTILITIES		
	GAS HEAT		24,459
	ELECTRICITY		88,121
	WATER		48,090
	CABLE TV - LOBBY		0
			0
			160,670
6	MAINTENANCE		
	GROUNDS MAINTENANCE		4,505
	PAINTING & DECORATING		657
	BUILDING REPAIRS		2,820
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		12,753
	ELEVATOR MAINTENANCE & REPAIR		3,440
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		3,213
	FIRE SERVICE		6,131
			0
			0
			0
			33,519
7	OTHER		
	SCAVENGER		11,765
	SECURITY SERVICE		0
			11,765
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	8,400
			8,400

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	
	LABORATORY & XRAY EXPENSE		6
	PURCHASED SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0
	PHARMACY CONSULTANT	XVIII B 39-2	0
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	0
	PSYCHIATRIC	XVIII B __-2	0
	RN CONSULTANT	XVIII B 38-2	0
	DENTAL SERVICE		3,600
			0
			3,606
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		9,545
	SPEECH THERAPY SERVICES		1,773
	OCCUPATIONAL THERAPY SERVICES		9,356
	THERAPY CONTRACT SERVICES	XVIII B __-2	19,675
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	7,200
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	7,200
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
			54,749
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0
			0
			0
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	2,320
			0
			2,320
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS	XIII	0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	109	109
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B 0	0
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C 23,539	
	ADMINISTRATIVE CONSULTANTS	XIX C 0	
	PROFESSIONAL FEES	XIX C 248,521	
		0	272,060
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F 0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F 3,742	
	EMPLOYEE WANT ADS	XIX F 7,939	
	CONTRIBUTIONS	VI 20 XIX F 0	
	DUES & SUBSCRIPTIONS	XIX F 11,502	
	LICENSES & PERMITS	XIX F 4,415	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F 0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F 0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F 150	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F 0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F 1,308	29,056
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,107	
	EQUIPMENT REPAIR & MAINTENANCE	5,143	
	OUTSIDE CLERICAL SERVICES	121,800	
	PENALTIES / OVERDRAFT CHARGES	VI 18 21,968	
	HOME OFFICE EXPENSE	0	
	THEFT & DAMAGE LOSS	568	
	TELEPHONE	23,858	
	MESSENGER SERVICE	1,714	
		0	176,158

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D 205,884	
	UNEMPLOYMENT COMPENSATION	XIX D 28,714	
	WORKERS COMPENSATION INSURANCE	XIX D 40,875	
	HOSPITALIZATION INSURANCE	XIX D 109,023	
	EMPLOYEE BENEFITS - OTHER	XIX D 3,861	
	EMPLOYEE PHYSICAL EXAMS	XIX D 0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D 0	
	UNION PENSION FUND/401K EXPENSE	XIX D 27,844	
	CHICAGO HEAD TAX	XIX D 0	416,201
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	2,152	2,152
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G 2,353	
	TRAVEL	XIX G 0	
		0	
		0	2,353
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	2,768	2,768
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	147,125	147,125
27	OTHER		
	BAD DEBTS	VI 24 0	
		0	0

GRAND TOTAL COLUMN 3 OTHER 1,335,427

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			59,423	59,423		59,423	(13,135)	46,288			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			97,698	97,698		97,698	38,138	135,836			32
33	Real Estate Taxes			94,155	94,155		94,155		94,155			33
34	Rent-Facility & Grounds			629,376	629,376		629,376	8,379	637,755			34
35	Rent-Equipment & Vehicles			43,884	43,884		43,884	6,490	50,374			35
36	Other (specify):*											36
37	TOTAL Ownership			924,536	924,536		924,536	39,872	964,408			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		102,980	183,054	286,034		286,034	(32,940)	253,094			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			111,143	111,143		111,143		111,143			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		102,980	294,197	397,177		397,177	(32,940)	364,237			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,727,935	559,499	2,554,160	5,841,594		5,841,594	43,150	5,884,744			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(22,972)	30		9
10	Interest and Other Investment Income	(82)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,093)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(150)	20		17
18	Fines and Penalties	(21,968)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(3,742)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PAGE 5A	(19,949)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (69,956)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	113,106		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 113,106		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 43,150		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 2,498	6	1
2	DIRECTOR OF MARKETING	(22,447)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(19,949)		49

Summary A

12/31/2003

[illegible]

Summary B

12/31/2003

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				CAREPLUS MGMT.	NILES	MGMT/CLERICAL
				CAREPLUS REHAB.	NILES	THERAPY
SEE ATTACHED SCHEDULE						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	DIETARY CONSULT. FEES	\$ 7,200	CAREPLUS MANAGEMENT, INC		\$	\$ (7,200)	1
2	V	19	DATA PROCESS FEES	14,400	" "			(14,400)	2
3	V	21	CLERICAL FEES	121,800	" "			(121,800)	3
4	V	1	DIETARY SALARIES		" "		9,762	9,762	4
5	V	5	ELECTRICITY		" "		175	175	5
6	V	6	MAINT & REPAIRS		" "		299	299	6
7	V	6	MAINTENANCE SALARIES		" "		6,537	6,537	7
8	V	10	NURSING SALARIES		" "		24,849	24,849	8
9	V	10a	THERAPY SALARIES		" "		6,701	6,701	9
10	V	17	ADMIN SALARIES		" "		54,155	54,155	10
11	V	19	PROFESSIONAL FEES		" "		3,419	3,419	11
12	V	20	ADVERTISING		" "		4,281	4,281	12
13	V	21	TOTAL OFFICE		" "		21,459	21,459	13
14	Total			\$ 143,400			\$ 131,637	\$ * (11,763)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	THERAPY SERVICES	\$ 53,479	CAREPLUS REHABILITATIVE SERVICES		\$ 43,922	\$ (9,557)	15
16	V	39	ANCILLARY THERAPY	184,322	" "		151,382	(32,940)	16
17	V								17
18	V								18
19	V								19
20	V	21	CLERICAL SALARIES		CAREPLUS MGMT, INC.		62,009	62,009	20
21	V	23	SEMINARS		" "		731	731	21
22	V	24	TRAVEL		" "		656	656	22
23	V	25	TRANSPORTATION		" "		2,436	2,436	23
24	V	26	INSURANCE		" "		2,541	2,541	24
25	V	27	EMPLOYEE BENEFITS		" "		36,067	36,067	25
26	V	30	DEPRECIATION (SL)		" "		9,837	9,837	26
27	V	32	INTEREST		" "		38,220	38,220	27
28	V	34	OFFICE RENT		" "		8,379	8,379	28
29	V	35	EQUIPMENT RENT		" "		6,490	6,490	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 237,801			\$ 362,670	\$ * 124,869	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATIONS:								\$		1
2	SHERWIN RAY	PRESIDENT	ADMIN.FINANC	24.88	SEE ATTACHED	4.8	8.07	SALARY	14,936	17-7	2
3	JAKOB BAKST	DIR OPERATIONS	ADMIN,CONSUL	24.88	SCHEDULE	4.8	8.07	" "	14,936	17-7	3
4	JOE ZIMMERMAN	CFO	CLERICAL	0.99		4.8	8.07	" "	11,286	21-7	4
5	JANICE L. CLAFFORD	CONTROLLER	CLERICAL	0.99		4.8	8.07	" "	4,631	21-7	5
6	ROMY MACASAET	RN CONSULTANT	NURSING	0.49		4.8	8.07	" "	7,295	10-7	6
7	JAMEE O'BRIEN	REGIONAL DIR	ADMINISTRAT	0.49		4.8	8.07	" "	10,804	17-7	7
8	JOE ANN BREW	REGIONAL DIR	ADMINISTRAT	0.49		4.8	8.07	" "	5,238	17-7	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 69,126		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number GLENWOOD CARE CENTER# 0040394 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization CAREPLUS MANAGEMENT, INC.
Street Address 5940 W. TOUHY
City / State / Zip Code NILES, IL 60714
Phone Number (847) 647-1717
Fax Number (847) 647-0222

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1	<u>DIETARY SALARIES</u>	<u>CENSUS DAYS</u>	<u>451,761</u>	<u>9</u>	<u>\$ 96,016</u>	<u>\$ 90,016</u>	<u>45,930</u>	<u>\$ 9,762</u>	<u>1</u>
	2	<u>ELECTRICITY</u>	<u>CENSUS DAYS</u>	<u>568,908</u>	<u>13</u>	<u>2,165</u>		<u>45,930</u>	<u>175</u>	<u>2</u>
	3	<u>MAINT & REPAIRS</u>	<u>CENSUS DAYS</u>	<u>568,908</u>	<u>13</u>	<u>3,701</u>		<u>45,930</u>	<u>299</u>	<u>3</u>
	4	<u>MAINTENANCE SALARIES</u>	<u>CENSUS DAYS</u>	<u>568,908</u>	<u>13</u>	<u>80,966</u>	<u>80,966</u>	<u>45,930</u>	<u>6,537</u>	<u>4</u>
	5	<u>NURSING SALARIES</u>	<u>CENSUS DAYS</u>	<u>568,908</u>	<u>13</u>	<u>307,794</u>	<u>307,794</u>	<u>45,930</u>	<u>24,849</u>	<u>5</u>
	6	<u>THERAPY SALARIES</u>	<u>CENSUS DAYS</u>	<u>568,908</u>	<u>13</u>	<u>82,996</u>	<u>82,996</u>	<u>45,930</u>	<u>6,701</u>	<u>6</u>
	7	<u>ADMIN. SALARIES</u>	<u>CENSUS DAYS</u>	<u>568,908</u>	<u>13</u>	<u>670,787</u>	<u>670,787</u>	<u>45,930</u>	<u>54,155</u>	<u>7</u>
	8	<u>PROFESSIONAL FEES</u>	<u>CENSUS DAYS</u>	<u>568,908</u>	<u>13</u>	<u>42,352</u>		<u>45,930</u>	<u>3,419</u>	<u>8</u>
	9	<u>ADVERTISING</u>	<u>CENSUS DAYS</u>	<u>568,908</u>	<u>13</u>	<u>53,021</u>		<u>45,930</u>	<u>4,281</u>	<u>9</u>
	10	<u>TOTAL OFFICE</u>	<u>CENSUS DAYS</u>	<u>568,908</u>	<u>13</u>	<u>265,794</u>		<u>45,930</u>	<u>21,459</u>	<u>10</u>
	11	<u>CLERICAL SALARIES</u>	<u>CENSUS DAYS</u>	<u>568,908</u>	<u>13</u>	<u>768,069</u>	<u>768,069</u>	<u>45,930</u>	<u>62,009</u>	<u>11</u>
	12	<u>SEMINARS</u>	<u>CENSUS DAYS</u>	<u>568,908</u>	<u>13</u>	<u>9,053</u>		<u>45,930</u>	<u>731</u>	<u>12</u>
	13	<u>TRAVEL</u>	<u>CENSUS DAYS</u>	<u>568,908</u>	<u>13</u>	<u>8,124</u>		<u>45,930</u>	<u>656</u>	<u>13</u>
	14	<u>TRANSPORTATION</u>	<u>CENSUS DAYS</u>	<u>568,908</u>	<u>13</u>	<u>30,176</u>		<u>45,930</u>	<u>2,436</u>	<u>14</u>
	15	<u>INSURANCE</u>	<u>CENSUS DAYS</u>	<u>568,908</u>	<u>13</u>	<u>31,470</u>		<u>45,930</u>	<u>2,541</u>	<u>15</u>
	16	<u>EMPLOYEE BENEFITS</u>	<u>CENSUS DAYS</u>	<u>568,908</u>	<u>13</u>	<u>446,737</u>		<u>45,930</u>	<u>36,067</u>	<u>16</u>
	17	<u>DEPRECIATION (SL)</u>	<u>CENSUS DAYS</u>	<u>568,908</u>	<u>13</u>	<u>121,842</u>		<u>45,930</u>	<u>9,837</u>	<u>17</u>
	18	<u>INTEREST</u>	<u>CENSUS DAYS</u>	<u>568,908</u>	<u>13</u>	<u>473,414</u>		<u>45,930</u>	<u>38,220</u>	<u>18</u>
	19	<u>OFFICE RENT</u>	<u>CENSUS DAYS</u>	<u>568,908</u>	<u>13</u>	<u>103,790</u>		<u>45,930</u>	<u>8,379</u>	<u>19</u>
	20	<u>EQUIPMENT RENT</u>	<u>CENSUS DAYS</u>	<u>568,908</u>	<u>13</u>	<u>80,391</u>		<u>45,930</u>	<u>6,490</u>	<u>20</u>
	21									<u>21</u>
	22									<u>22</u>
	23									<u>23</u>
	24									<u>24</u>
	25	TOTALS				<u>\$ 3,678,658</u>	<u>\$ 2,000,628</u>		<u>\$ 299,003</u>	<u>25</u>

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	CIB BANK		X	CAPITAL IMPROVEMENT	\$4,739.35	02/01	\$ 336,000	\$ 106,614	02/06	PRIME +	\$ 10,562	1	
2	LOAN COSTS		X	LOAN COSTS	W/O OVER 5 YEARS		1,125	487	02/06		225	2	
3												3	
4												4	
5												5	
	Working Capital												
6	CAREPLUS MGMT INC	X		WORKING CAPITAL	DEMAND	04/95	1,300,000	2,115,000		PRIME +	86,911	6	
7												7	
8	CAREPLUS MGMT ALLOCATION										38,220	8	
9	TOTAL Facility Related				\$4,739.35		\$ 1,637,125	\$ 2,222,101			\$ 135,918	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 1,637,125	\$ 2,222,101			\$ 135,918	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	\$	83,388	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	88,330	2
3. Under or (over) accrual (line 2 minus line 1).	\$	4,942	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	89,213	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	94,155	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1998	72,032	8
	1999	75,565	9
	2000	79,467	10
	2001	82,562	11
	2002	88,330	12

FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	13
14	PLUS APPEAL COST FROM LINE 5	14
15	LESS REFUND FROM LINE 6	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

GLENWOOD CARE CENTER

COUNTY

WILL

FACILITY IDPH LICENSE NUMBER

0040394

CONTACT PERSON REGARDING THIS REPORT

BOB KAGDA

TELEPHONE (847) 675-3585

FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A)	(B)	(C)	(D)
				<u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
				<u>Nursing Home</u>
1.	30-07-07-304-025-0000	NURSING HOME	\$ 88,329.56	\$ 88,329.56
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 88,329.56	\$ 88,329.56

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 80,000

B. General Construction Type: Exterior BRICKFrame STEELNumber of Stories 2

C. Does the Operating Entity?

☐ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☒ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES☐ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME	75,625		\$	1
2					2
3	TOTALS	75,625		\$	3

Facility Name & ID Number GLENWOOD CARE CENTER

0040394

Report Period Beginning:

01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1993	1,080	34	31.5	34		364	9
10	LEASEHOLD IMPROVEMENTS			1993	26,757	686	39	686		7,165	10
11	LEASEHOLD IMPROVEMENTS			1994	4,980	128	39	128		1,253	11
12	OUTLETS			1995	1,429	37	39	37		307	12
13	PAVING			1995	19,500	1,300	15	1,300		11,056	13
14	ROOF REPAIR			1996	2,505	64	39	64		504	14
15	ELEVATOR REPAIR			1996	7,000	180	39	180		1,396	15
16	WATER CONDITIONING SYSTEM			1996	3,486	89	39	89		686	16
17	ROOFTOP A/C UNIT			1996	5,300	136	39	136		958	17
18	LANDSCAPING			1996	3,554	237	15	237		1,777	18
19	EXTERIOR PLASTER/PAINT			1997	8,500	218	39	218		1,481	19
20	PLUMBING			1997	1,091	28	39	28		186	20
21	LAMINATED COUNTER TOPS			1997	5,900	151	39	151		936	21
22	WALK-IN COOLER			1998	9,893	254	39	254		1,513	22
23	OUTDOOR STORAGE UNIT			1998	1,200	31	39	31		182	23
24	DRAIN LINE REPAIRS			1998	6,575	168	39	168		972	24
25	ROOFTOP HEAT / AC UNIT			1998	5,200	133	39	133		693	25
26	LANDSCAPING			1998	5,883	392	15	392		2,156	26
27	ROOF & HEATING REPAIRS / FIRE SAFETY UPGRADE			1999	17,798	456	39	456		1,906	27
28	NEW SUSPENDED CELLING			2000	64,670	2,352	27.5	2,352		9,021	28
29	CARPET-ENTRANCE & LOBBY			2000	2,750	387	20	138	(249)	552	29
30	NEW DIALYSIS ROOM			2001	8,750	318	27.5	318		914	30
31	INSTALLATION WATER SYSTEM			2001	1,905	69	27.5	69		199	31
32	FIRE ALARM SYSTEM-NEW HORNS,SMOKE DETECTORS			2001	7,194	262	27.5	262		600	32
33	DRYWALL			2001	5,425	197	27.5	197		452	33
34	PASSENGER ELEVATOR-PUMPING UNIT			2001	9,700	353	27.5	353		721	34
35	REPLACE WATER HEATER			2001	4,411	160	27.5	160		327	35
36	ROOF REPAIR			2002	3,100	113	27.5	113		202	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number GLENWOOD CARE CENTER

0040394

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	NURSES STATION WITH SURFACE TRANSACTION TOP	2002	\$ 17,820	\$ 648	27.5	\$ 648	\$	\$ 783	37
38	VESTIBULE, LOBBY,DINING ROOMS - WALLCOVERING	2002	7,200	262	27.5	262		454	38
39	REPLACE THE ELEVATOR PUMPING UNIT	2002	4,700	171	27.5	171		306	39
40	NURSES' STATIONS-WALLCOVERING, ELECTRIC. WORK	2002	5,440	198	27.5	198		271	40
41	REPAIR PATCH AT FRONT OF BUILDING	2002	1,720	115	15	115		230	41
42	BUILD NEW WALL BETWEEN LOBBY & NURSES STATION	2002	6,930	252	27.5	252		326	42
43	LOBBY, VESTIBULE, CORRIDOR-FLOORING	2002	34,654	1,260	27.5	1,260		1,523	43
44	FACILITY DOOR	2003	3,072	60	27.5	60		60	44
45	GREASE TRAPS	2003	3,900	77	27.5	77		77	45
46	DELAYS FOR PATIO DOORS	2003	3,049	60	27.5	60		60	46
47	FENCE	2003	3,950	132	15	132		132	47
48	ROOF DRAIN	2003	1,900	9	27.5	9		9	48
49	FIRE ALARM SYSTEM	2003	6,198	28	27.5	28		28	49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57	CAREPLUS MGMT INC.: LEASEHOLD IMPROVEMENTS			95		95			57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 346,069	\$ 12,300		\$ 12,051	\$ (249)	\$ 52,738	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 215,605	\$ 20,323	\$ 19,713	\$ (610)	8-15	\$ 102,666	71
72	Current Year Purchases	42,637	24,126	2,132	(21,994)	5-10	2,132	72
73	Fully Depreciated Assets	7,300					7,300	73
74	RELATED PARTY ALLOC SL DEPR		9,742	9,742				74
75	TOTALS	\$ 265,542	\$ 54,191	\$ 31,587	\$ (22,604)		\$ 112,098	75

D. Vehicle Depreciation (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76	FACILITY	1998 CHEVROLET VAN	2001	\$ 13,250	\$ 2,769	\$ 2,650	\$ (119)	5	\$ 7,950
77									77
78									78
79									79
80	TOTALS			\$ 13,250	\$ 2,769	\$ 2,650	\$ (119)		\$ 7,950

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	624,861
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	69,260
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	46,288
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(22,972)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	172,786

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: METROPOLITAN NURSING CENTER OF JOLIET
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1970	203	04/01/93	\$ 629,376	30		3
4	Additions							4
5								5
6								6
7	TOTAL		203		\$ 629,376			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: YES NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? YES NO X
16. Rental Amount for movable equipment: \$ 43,884 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	\$
13.	/2005	\$
14.	/2006	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 105,665	\$		\$ 105,665	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			7,988			7,988	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			69,401			69,401	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				92,428		92,428	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MEDICAL SUPPLIES Other (specify): LAB. / RENTALS	39-2 39-2					1,834 8,718		<div>1,834</div> <div>8,718</div>	13
14	TOTAL			\$		\$ 183,054	\$ 102,980		\$ 286,034	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (79,172)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,283,173		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,164		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	96,060		8
9	Other(specify): Real Estate Tax Escrow	72,429		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,385,654	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	346,069		15
16	Equipment, at Historical Cost	278,792		16
17	Accumulated Depreciation (book methods)	(277,976)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	487,200		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CAPITAL IMPV LOAN FEES	487		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 834,572	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,220,226	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 800,236	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	36,979		28
29	Short-Term Notes Payable	2,221,614		29
30	Accrued Salaries Payable	68,946		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,096		31
32	Accrued Real Estate Taxes(Sch.IX-B)	89,213		32
33	Accrued Interest Payable	6,647		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,234,731	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,234,731	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (14,505)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,220,226	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 512,844	1
2	Restatements (describe):		2
3	ROUNDING	9	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 512,853	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(527,358)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (527,358)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (14,505)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,291,808	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,291,808	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	22,346	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 22,346	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	82	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 82	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,314,236	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,066,007	31
32	Health Care	2,203,213	32
33	General Administration	1,250,661	33
	B. Capital Expense		
34	Ownership	924,536	34
	C. Ancillary Expense		
35	Special Cost Centers	286,034	35
36	Provider Participation Fee	111,143	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,841,594	40
41	Income before Income Taxes (line 30 minus line 40)**	(527,358)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (527,358)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.
TAX RETURN PREPARED ON CASH BASIS

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,177	2,266	\$ 66,412	\$ 29.31	1
2	Assistant Director of Nursing	1,315	1,366	31,231	22.86	2
3	Registered Nurses	19,419	20,483	489,585	23.90	3
4	Licensed Practical Nurses	18,326	19,226	376,840	19.60	4
5	Nurse Aides & Orderlies	75,456	79,169	747,936	9.45	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,153	4,387	60,158	13.71	8
9	Activity Director	1,894	2,016	25,781	12.79	9
10	Activity Assistants	9,235	9,717	65,599	6.75	10
11	Social Service Workers	6,567	7,007	130,368	18.61	11
12	Dietician					12
13	Food Service Supervisor	1,989	2,095	35,042	16.73	13
14	Head Cook	6,677	7,217	63,230	8.76	14
15	Cook Helpers/Assistants	12,470	13,187	93,807	7.11	15
16	Dishwashers					16
17	Maintenance Workers	4,141	4,419	57,164	12.94	17
18	Housekeepers	22,016	23,511	187,209	7.96	18
19	Laundry	7,384	7,868	58,143	7.39	19
20	Administrator	2,261	2,441	63,688	26.09	20
21	Assistant Administrator	1,958	1,995	31,343	15.71	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,744	6,017	93,930	15.61	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,081	2,224	20,302	9.13	31
32	Other Health Care(specify)					32
33	Other(specify)	3,882	3,912	30,167	7.71	33
34	TOTAL (lines 1 - 33)	209,145	220,523	\$ 2,727,935 *	\$ 12.37	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 7,200	1-3	35
36	Medical Director	O	8,400	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	0	10-3	39
40	Physical Therapy Consultant	L	7,200	10a-3	40
41	Occupational Therapy Consultant	Y	7,200	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	2,320	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 32,320		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount		Description	Amount
MICHAEL TORAL	ADMIN	0	\$ 21,826	Workers' Compensation Insurance	\$	40,875	IDPH License Fee	\$
TAMMY STONBERGER	ADMIN	0	41,862	Unemployment Compensation Insurance		28,714	Advertising: Employee Recruitment	7,939
HELENA MATHEWS	ASST ADMIN	0	7,996	FICA Taxes		205,884	Health Care Worker Background Check	1,308
DAVOD ROME	ASST ADMIN	0	15,809	Employee Health Insurance		109,023	(Indicate # of checks performed 94)	
AMY WALKO	ASST ADMIN	0	7,538	Employee Meals		#REF!	MARKETING/ADV/PROMO	3,742
				Illinois Municipal Retirement Fund (IMRF)*			TRUST/FRANCHISE/CONTRIB/ETC	150
				EMPLOYEE BENEFITS - OTHER		3,861	LICENSES & PERMITS	4,415
				EMPLOYEE PHYSICAL EXAMS		0	DUES & SUBSCRIPTIONS	11,502
				PENSION/PROFIT SHARING PLANS		27,844	MGMT CO ALLOCATION	4,281
TOTAL (agree to Schedule V, line 17, col. 1)				CHICAGO HEAD TAX		0	TRUST/FRANCHISE/CONTRIB/ETC	(150)
(List each licensed administrator separately.)			\$ 95,031	INSURANCE - EXECUTIVE LIFE		0	Less: Public Relations Expense	(0)
B. Administrative - Other							Non-allowable advertising	(3,742)
Description			Amount	INSURANCE - EXECUTIVE LIFE VI 21		0	Yellow page advertising	(0)
			\$ 0					
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$	#REF!	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 29,445
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount					
CAREPLUS MGMT	DATA PROCESSING		\$ 14,400				Out-of-State Travel	\$
HDSI	DATA PROCESSING		1,697					
AMERICAN DATA	DATA PROCESSING		2,490					
NATIONAL DATACARE	DATA PROCESSING		1,724				In-State Travel	
ACHIEVE HEALTHCARE	DATA PROCESSING		3,228					0
KBKB	ACCOUNTING		27,900				MGMT CO ALLOCATION	656
MEYER MAGENCE	LEGAL		21,433					
ECONOCARE	PURCHASE CONSULTANT		3,654				Seminar Expense	
PERSONNEL PLANNERS	UC CONSULTANT		1,159					2,353
MANAGEMENT PROFESSIONAL			189,575					
RICHARD PEELO	MEDICARE CONSULTANT		4,800					
			0				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 272,060				TOTAL	\$ 3,009

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINTING/DECORATING	1999	\$ 10,434	3 YRS	\$ 3,478	\$ 3,478	\$ 1,739	\$	\$	\$	\$	\$	\$
2	PAINTING/DECORATING	2000	8,643	3 YRS	1,440	2,881	2,881	1,441					
3	PAINTING/DECORATING	2002	3,172	3 YRS			529	1,057	1,057	529			
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 22,249		\$ 4,918	\$ 6,359	\$ 5,149	\$ 2,498	\$ 1,057	\$ 529	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LONG TERM CARE \$9,664
- (3) Did the nursing home make political contributions or payments to a political organization? NO If YES, have these costs been properly adjusted out of the cost report? NO
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,967 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 111,143
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ #REF! Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees